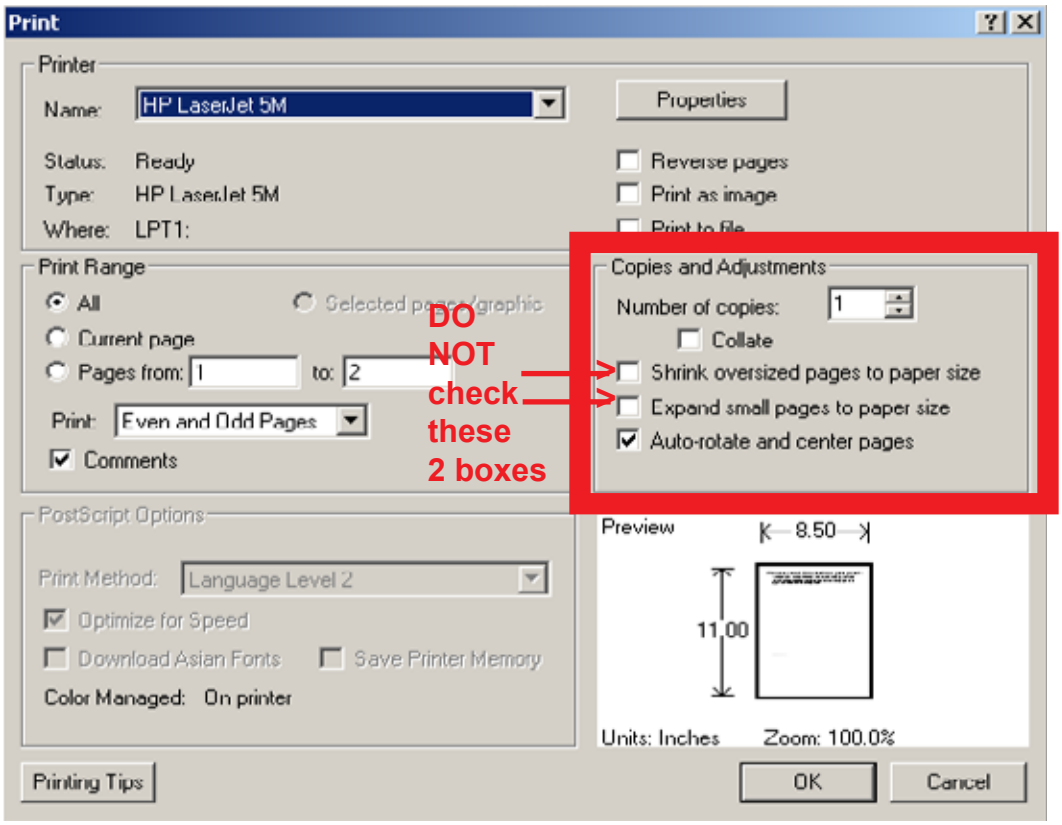
Please read this before you print.

To print applications correctly, it is important to set up your print request as shown below. In the Adobe Acrobat Print dialog box, you must check the box "Auto-rotate and center pages." Do **not** check the Shrink or Expand boxes.



DOH 600-033 (6/2006)

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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

A. Contents:

Apprentice Ocularist Application Packet

B. Important Social Security Number Information:

* Federal and state laws require the Department of Health to collect your Social Security Number before your professional license can be issued. A U.S. Individual Taxpayer Identification Number (ITIN) or a Canadian Social Insurance Number (SIN) cannot be substituted. If you submit an application but do not provide your Social Security Number, you will not be issued a professional license and your application fee is not refundable.
* Federal Personal Responsibility and Work Opportunity Reconciliation Act of 1996, 42 USC 666, RCW 26.23 and WAC 246-12-340.

C. In order to process your request:

1. Complete the Deposit Slip below.
2. Cut Deposit Slip from this form on the dotted line below.
3. Send application with check and Deposit Slip to **PO Box 1099, Olympia, WA 98507-1099**.

Cut along this line and return the form below with your completed application and fees.

Apprentice Ocularist

DEPOSIT SLIP

NAME (Please Print) _____ DATE _____

Revenue Section
P.O. Box 1099
Olympia, Washington 98507-1099

Please note amount enclosed, and return with your application.

$ _____

☐ **Check**
☐ **Money Order**

DOH 678-004 (REV 6/2006)

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Washington State Department of Health
Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

Application For Apprentice Ocularist Instructions

When your application for ocularist apprentice is received by the Department of Health, you will be sent an acknowledgment letter noting receipt, and any outstanding documentation needed to complete the process.

To ensure that you have submitted the necessary fees and documentation, we encourage you to use the following checklist.

☐ Pay Application Fee of $25.00. **(All fees are non-refundable)**

☐ **Box #1: Demographic Information:**

Name: Please list your current name with middle initial.

Mailing Address: Please identify the address to which you wish all correspondence, including your credential, delivered. This will become your address of record for all Department of Health transactions until we are notified of a change.

Telephone Number: Enter current number where you may be reached during normal business hours.

Social Security Number: Required for licensure under 42 USC 666 and Chapter 26.23 RCW.

Additional Data: This information is required to update the Department's Database.

☐ **Box #2: Supervisor Information.**

Supervisor Name: List supervisor's name and license number as it appears on his or her professional license.

Business Name: List business name if applicable.

Telephone: List supervisor's business telephone number.

Business Address: List supervisor's business address.

☐ **Box #3: Supervisor's Statement.** The supervisor signs the statement after reading.

☐ **Box #4: Personal Data.** Answer all questions. If you answer "yes" to any of the Personal Data Questions, you must submit the additional supporting documentation for that question, as indicated on the application. A "yes" response will not necessarily result in application denial, however, failure to honestly respond could be grounds to deny an application. Where specific statutes are indicated, be sure to read the appropriate statute prior to answering the question.

☐ **Box #5: Applicant's Attestation.** Required to be signed and dated in order to process the application. Please read thoroughly to ensure your understanding of the provisions in this section.

Make the fee payable to the Department of Health.

Fees must accompany the application and are non-refundable.

Applications and fees are to be sent to:

Department of Health
Ocularist Program
PO Box 1099
Olympia, WA 98507-1099

Please contact Program Staff at (360) 236-4825 with any questions.

Washington State Department of Health

Health Professions Quality Assurance
P.O. Box 1099
Olympia, WA 98507-1099

FOR OFFICE USE ONLY	
LICENSE #	ISSUANCE DATE

License #

Application For Apprentice Ocularist

Please Type or Print Clearly—Follow carefully all instructions provided. It is the responsibility of the applicant to submit or request to have submitted all required supporting documents. Failure to do so could result in a delay in processing your application.

All applications must be accompanied by the applicable fee. Make remittance payable to the Department of Health.

1. Demographic Information

APPLICANT'S NAME LAST FIRST MIDDLE INITIAL

RESIDENTIAL ADDRESS

CITY	STATE	ZIP	COUNTY

NOTE: Your certification document will show this address and all correspondence from the Department will be sent to this address until you notify us in writing of a change. Pursuant to WAC 246-12-310, it is your responsibility to maintain a current mailing address on file with the Department.

TELEPHONE (ENTER THE NUMBER AT WHICH YOU CAN BE REACHED DURING **NORMAL BUSINESS** HOURS.)

( )

SOCIAL SECURITY NUMBER (**Required** for license under 42 USC 666 and Chapter 26.23 RCW)

— —

GENDER	BIRTHDATE (MO/DAY/YEAR)	PLACE OF BIRTH (CITY/STATE)
☐ Female ☐ Male	/ /	

Have you ever been known under any other name(s)? ☐ Yes ☐ No

If yes, list other name(s):

2. Supervisor Information

Supervisor's Name _____ License No. _____

Business Name _____

Business Address _____

3. Supervisor Statement

I request that _____ be registered under my supervision as
APPLICANT'S NAME

an apprentice ocularist.

I, _____, certify that I am qualified to act as an
LICENSEE'S NAME

apprentice ocularist supervisor and that I have read and am familiar with Chapter 18.34 RCW and Chapter 246-824 WAC relating to the training and registration of apprentice ocularists. I will record the beginning and ending dates of supervision of this apprentice and maintain a record of total hours worked under my supervision. I understand that I may not have more than two (2) apprentices under my supervision at any one time.

Licensee's Signature _____ Date _____

4. Personal Data Questions

YES NO

1. Do you have a medical condition which in any way impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Medical Condition" includes physiological, mental or psychological conditions or disorders, such as, but not limited to orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction and alcoholism.

   1a. If you answered "yes" to question 1, please explain whether and how the limitations or impairments caused by your medical condition are reduced or eliminated because you receive ongoing treatment (with or without medications).

   1b. If you answered "yes" to question 1, please explain whether and how the limitations and impairments caused by your medical condition are reduced or eliminated because of your field of practice, the setting or the manner in which you have chosen to practice.

   (If you answered "yes" to question 1, the licensing authority (Board/Commission or Department as appropriate) will make an individualized assessment of the nature, the severity and the duration of the risks associated with an ongoing medical condition, the ongoing treatment, and the factors in "1b" so as to determine whether an unrestricted license should be issued, whether conditions should be imposed, or whether you are not eligible for licensure.)

2. Do you currently use chemical substance(s) in any way which impairs or limits your ability to practice your profession with reasonable skill and safety? If yes, please explain. ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Chemical substances" includes alcohol, drugs or medications, including those taken pursuant to a valid prescription for legitimate medical purposes and in accordance with the prescriber's direction, as well as those used illegally.

3. Have you ever been diagnosed as having or have you ever been treated for pedophilia, exhibitionism, voyeurism or frotteurism? ☐ ☐

4. Are you currently engaged in the illegal use of controlled substances? ☐ ☐

   "Currently" means recently enough so that the use of drugs may have an ongoing impact on one's functioning as a licensee, and includes at least the past two years.

   "Illegal use of controlled substances" means the use of controlled substances obtained illegally (e.g., heroin, cocaine) as well as the use of legally obtained controlled substances, not taken in accordance with the directions of a licensed health care practitioner.

Note: If you answer "yes" to any of the remaining questions, provide an explanation and certified copies of all judgments, decisions, orders, agreements and surrenders. The Department does criminal background checks on all applicants.

5. Have you ever been convicted, entered a plea of guilty, nolo contendere or a plea of similar effect, or had prosecution or sentence deferred or suspended, in connection with:

   a. the use or distribution of controlled substances or legend drugs? ☐ ☐

   b. a charge of a sex offense? ☐ ☐

   c. any other crime, other than minor traffic infractions? (Including driving under the influence and reckless driving) ☐ ☐

6. Have you ever been found in any civil, administrative or criminal proceedings to have:

   a. possessed, used, prescribed for use, or distributed controlled substances or legend drugs in any way other than for legitimate or therapeutic purposes, diverted controlled substances or legend drugs, violated any drug law, or prescribed controlled substances for yourself? ☐ ☐

   b. committed any act involving moral turpitude, dishonesty or corruption? ☐ ☐

   c. violated any state or federal law or rule regulating the practice of a health care professional? ☐ ☐

7. Have you ever been found in any proceeding to have violated any state or federal law or rule regulating the practice of a health care profession? If "yes", explain and provide copies of all judgments, decisions, and agreements. ☐ ☐

8. Have you ever had any license, certificate, registration or other privilege to practice a health care profession denied, revoked, suspended, or restricted by a state, federal, or foreign authority, or have you ever surrendered such credential to avoid or in connection with action by such authority? ☐ ☐

9. Have you ever been named in any civil suit or suffered any civil judgment for incompetence, negligence or malpractice in connection with the practice of a health care profession? ☐ ☐

5. Applicant's Attestation

I, _____ , certify that I am the person described and identified in
NAME OF APPLICANT

this application; that I have read RCW 18.130.170 and 180 of the Uniform Disciplinary Act; and that I have answered all questions truthfully and completely, and the documentation provided in support of my application is, to the best of my knowledge, accurate. I further understand that the Department of Health may require additional information from me prior to making a determination regarding my application, and may independently validate conviction records with official state or federal databases.

I hereby authorize all hospitals, institutions or organizations, my references, employers (past and present), business and professional associates (past and present), and all governmental agencies and instrumentalities (local, state, federal, or foreign) to release to the Department any information files or records required by the Department in connection with processing this application.

I further affirm that I will keep the Department informed of any criminal charges and/or physical or mental conditions which jeopardize the quality of care rendered by me to the public.

Should I furnish any false or misleading information on this application, I hereby understand that such act shall constitute cause for the denial, suspension, or revocation of my license to practice in the State of Washington.

_____ _____
SIGNATURE OF APPLICANT DATE

Attach Current Photograph Here.
Indicate Date Taken and Sign in Ink Across Bottom of the Photo.

NOTE: Photograph **Must** Be:

1. Original, not a photocopy
2. No larger than 2" X 2"
3. Taken within one year of application
4. Close up, front view—not profile
5. Instant Polaroid Photographs **not** acceptable

Official Use Only

Washington State Records Center

Health Professions Quality Assurance
Ocularist Program
P.O. Box 1099
Olympia, WA 98507-1099
(360) 236-4948

Training Certification for Apprentice Ocularist

PLEASE TYPE OR PRINT CLEARLY

Supervisor's Full Name _____
LAST NAME FIRST NAME MIDDLE INITIAL

Business Name _____

Business Address _____

_____ ☐
CITY STATE ZIP CODE COUNTY

Daytime Telephone Number _____

Licensed to practice as _____

License Number _____

I certify that (Apprentice's Name) _____

has been under my direct supervision as an Apprentice Ocularist for the period beginning:

_____ _____ , _____ and ending:
MONTH DAY YEAR

_____ _____ , _____ and has accrued a total of _____
MONTH DAY YEAR

apprenticeship hours while under my supervision.

I, _____ , certify that I am the person
PRINT OR TYPE FULL NAME OF DIRECT SUPERVISOR

identified above as the supervisor and that to the best of my knowledge and belief the statements made in this affidavit are true and correct.

_____ _____
SIGNATURE DATE